MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9/a

06981

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Pomonkey Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Pomonkey md
(If outside city or town limits, write RURAL and give nearest town)
Street No. /
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Armstrong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 76 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: St Mary Co Md
(Town, county, and state)

10. Usual occupation: Farm work

11. Industry or business

FATHER
12. Name: Robert Sewell
13. Birthplace: Md

MOTHER
14. Maiden name: Maria Jordon
15. Birthplace: St Mary Co Md

16. Informant: Isaac Armstrong
Address: Pomonkey

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 7 1947 (month) (day) (year)
Cemetery or crematory: St Joseph
Location: Pomfret Md

18. Funeral director: Smith & Lyon
Address: Waldorf Md

19. 8/25/1947 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-23 19 47, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 10 1947
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	8-23-47
Due to: Sen. Art. Sclerosis	? ?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: La Plata Md Date signed 8-23-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06982

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH

County: Charles

City or town: Cobb Point Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Chas

City or town: Cobb Point Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jessie Butler

3. (b) Social Security Number

4. Sex: M | 5. Color or race: Col | 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 16, 1884

8. AGE: Years: 62 | Months: 7 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cobb Point Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: Julia Jackson

15. Birthplace

16. Informant: Anthony Butler

Address: Cobb Point md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-4-47 (month) (day) (year)

Cemetery or crematory: Shiloh

Location: Wayside Md

18. Funeral director: Hewitt & Ryan

Address: Waldorf, Md

19. 8-6 1947 (Date rec'd by registrar) Wm. J. Keene Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1947 at 1 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 2 1947

and that I last saw h.. l.. alive on Aug 1 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	7-2-47
Due to: Hypertension Heart Disease	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: E. Redden M.D. M. D. or other

Address: La Plata, Md Date signed 8-2-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

P6983

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:
County Chas
City or town Mt Victoria
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Chas
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mt Victoria, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Suzanne Colbert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Wid

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
82			..... hrs. ..... min.

9. Birthplace Chas Co Md (Town, county, and state)
10. Usual occupation Farm work
11. Industry or business

FATHER
12. Name James Brown
13. Birthplace St Mary Co Md

MOTHER
14. Maiden name Isabella
15. Birthplace St Mary Co Md

16. Informant Isabell Hutchens
Address 3333 Stephenson Place N

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-24-47 (month) (day) (year)
Cemetery or crematory Shiloh M. E.
Location Newburg Md
18. Funeral director Smith & Ryon
Address Waldorf Md

19. Aug 22 19 47 (Date rec'd by registrar) W. L. Rogers Registrar

MEDICAL CERTIFICATION EST

20. DATE OF DEATH 22 August 19 47, at 1:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 August 1947 to 22 Aug 1947 and that I last saw h.. alive on 21 August 47 19....

Immediate cause of death	DURATION
Heart failure	3 mo.
Due to Chronic hypertensive heart disease with failure	18 mo.
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. J. Woodall M.D. M. D. or other
Address La Plata, Md. Date signed 22 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06984

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Physicians' Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Hughesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wilbert Combs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name ~~of husband or~~ wife: Ellen P.

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): April 10, 1890

8. AGE: Years	Months	Days	If less than one day
57	4	10	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: Albert Combs

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ada L. Combs

MOTHER — 15. Birthplace: Maryland

16. Informant: Ellen P. Combs

Address: Hughesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/47 (month) (day) (year)

Cemetery or crematory: Holy Face

Location: Fred Mills

18. Funeral director: C B Robinson

Address: Leonardtown

19. 8/21/47 (Date rec'd by registrar) Cannalin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 August 1947, at 11:23 AM EST

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 August 1947 to 20 August 1947 and that I last saw h.. alive on 20 August 1947

Immediate cause of death	Coronary occlusion	DURATION 12 hrs
Due to	—	
Due to	—	
Other conditions	—	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A B Woodly M.D. (M. D. or other)

Address: La Plata, Md. Date signed: 20 Aug 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06985

55e

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:

County Charles.

City or town Bryantown.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life time, 76 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Charles.

City or town Bryantown.
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Benjamin Marcellinus Edelen. II

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married.

6.(b) Name of husband or wife Mary Boarman

7. Birth date of deceased (mo., day, yr.) Sept 19, 1872 1871 6.(c) If alive, give age 75 years

8. AGE: Years 75 | Months 11 | Days ~~5~~ | If less than one day ... hrs. ... min.

9. Birthplace Bryantown, Char., Md.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER 12. Name Benjamin M Edelen.

13. Birthplace Bryantown. Md.

MOTHER 14. Maiden name Mary T Gardiner

15. Birthplace Bryantown.

16. Informant Daughter, Glyndon
Address Bryantown, Md.

17. Burial Date thereof 8-16-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Mary

Location Bryantown

18. Funeral director Hewett & Rogers

Address Waldorf Md

19. Aug 15 47 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 August 1947 at 4:00 P M EST.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 MAY 1947 to 12 AUGUST 1947 and that I last saw h.in alive on 12 August 1947

Immediate cause of death	DURATION
Respiratory collapse.	
Due to Occlusion of trachea	
Due to Cancer of the parotid with metastasis to trachea and	18 mo.
Other conditions generalized run-out body	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op Adenocarcinoma.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically. Cancer, Operated, Mixed.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of —

Where did injury occur? None
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Arthur O. Wooddy, MD
M. D. or other

Address Box 214 La Plata, Md. Date signed 12 Aug 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a B

06986

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH: County Prince Georges County, Md. City or town (If outside city or town limits, write RURAL and give nearest town) Laurel How long in above place of death? 2 weeks Hospital, institution, or street address where death occurred: Malcolm, Maryland How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State County City or town Washington D.C. (If outside city or town limits, write RURAL and give nearest town) Street No. 1213 - Lamont St. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARY HAWKINS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Blk Colored	Widow

6.(b) Name of husband or wife Leonard Hawkins 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1861

8. AGE: Years 86 | Months | Days | If less than one day hrs. min.

9. Birthplace Chas. Co. Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James Thomas

13. Birthplace Chas. Co. Md.

MOTHER 14. Maiden name Jane Green

15. Birthplace Chas. Co. Md.

16. Informant Ina Thomas Address Malcolm, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 16 1947 (month) (day) (year)

Cemetery or crematory Lincoln Mem

Location Washington D.C.

18. Funeral director Eugene Funeral Home Address 1213 H St. N.W.

19. Aug 11 1947 (Date rec'd by registrar) M. L. Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 11 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG 1 1947, to 19; and that I last saw h ex alive on AUG 1 19

Immediate cause of death	DURATION
CIRCULATORY COLLAPSE	
Due to CARONARY THROMBOSIS	
Due to ARTERIOSCLEORIS, DIFFUSE	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred L. Lapen M.D. M. D. or other

Address Chasco Md Date signed Aug 12 1947 2 AM

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06987

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Md. Highway 488
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Ignatius Myles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Rachel Elizabeth Johnson
6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1921

8. AGE: Years 25 | Months | Days | If less than one day hrs. min.

9. Birthplace White Plains Md (Town, county, and state)
10. Usual occupation Schaumper
11. Industry or business
12. FATHER Name William Ignatius Miles
13. Birthplace White Plains Md
14. MOTHER Maiden name Evangeline Lee
15. Birthplace La Plata Md
16. Informant La Verne Houston
Address Lawrenceville N J
17. Buried (Burial, cremation, or removal. Which?) Date thereof 9-3-47 (mooth) (day) (year)
Cemetery or crematory St Joseph
Location Bryantown Md
18. Funeral director Hurst & Posey
Address Waldorf Md
19. 9/3 1947 (Date rec'd by registrar) Julia Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1947 at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from on Aug 31 1947 to 19 and that I last saw him alive on Aug 31, 1947

	DURATION
Immediate cause of death Lacerated wound both common carotid arteries	Seconds
Due to Auto accident	Seconds
Due to	
Other conditions Compound fracture left arm	Simple

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-31-47
Where did injury occur? La Plata Charles Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) State Highway
Means of injury Hit truck Injured at work? No
Deputy Medical Examiner
23. SIGNATURE Jos. F. MacDonough M.D.
M. D. or other
Address Address Date signed 9-3-47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06988

(109)

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Rural, Welcome, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Charles.

City or town: Rural, Welcome.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Indian Town Farm.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Joseph Thomas Neal, jr.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro.	Single.

6.(b) Name of husband or wife: —

6.(c) If alive, give age: August 2. 1947 — 15 days. years

7. Birth date of deceased (mo., day, yr.): Aug 2, 1947

8. AGE:

Years	Months	Days	If less than one day
0	0	15	— hrs. — min.

9. Birthplace: Indian Town Farm, Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Joseph Thomas Neal
13. Birthplace: St. Marys Co, Md.

MOTHER
14. Maiden name: Mary Blanche Key.
15. Birthplace: Mechanicsville, Maryland

16. Informant: Mother, Mary Blanch Neal
Address: Indian Town Farm.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 1947 (month) (day) (year)

Cemetery or crematory: —

Location: Mt. Carmel, Md.

18. Funeral director: Joseph Thomas Neal
Address: Welcome, Md

19. 8-17 19 47 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

EST

20. DATE OF DEATH: 17 August 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 August 19 47 to 17 August 19 47 and that I last saw him alive on 17 August 19 47

Immediate cause of death	DURATION
Respiratory failure.	
Due to Pneumonia, Bronchial (9/24/47 OS)	
Due to	
Other conditions: none.	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: none. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. J. Woodly, M.D.
M. D. or other

Address: La Plata, Md. Date signed: 17 Aug 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mail to:
Miss Posey Memorial Hospital
Physicians
La Plata, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a B 06989

Reg. Diat. No. 100

1. PLACE OF DEATH:

County Charles

City or town La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred:

Physicians Memorial Hospital.

How long in hospital or institution? 48 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Nth Carolina County Granville

City or town Oxford.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 New College

(If rural, give LOCATION)

2.(a) If veteran, name war Vet World War I. ✓

3. (a) FULL NAME HUGH Freeland PEED

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married.

6.(b) Name of ~~husband~~ or wife Ruth Wreenn PEED

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26 1894

8. AGE: Years 53 | Months ~~2~~ 3 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Oxford, Granville Co. (Town, county, and state)

10. Usual occupation Tobacco.

11. Industry or business

FATHER 12. Name GRAHAM PEED

13. Birthplace Granville Co N.C.

MOTHER 14. Maiden name ELLA FULLER

15. Birthplace Granville Co. N.C.

16. Informant Sister, Mrs Floyd Parham

Address Oxford, N.C.

17. Burial & Removal (Burial, cremation, or removal, Which?) Date thereof 8-31-47 (month) (day) (year)

Cemetery or crematory Elmwood

Location Yorkville N.C.

18. Funeral director Hunt & Ryan

Address Woodsboro

19. 9-3 1947 (Date rec'd by registrar) Julia H. Rees Registrar

MEDICAL CERTIFICATION EST

20. DATE OF DEATH 30 August 1947, at 3:18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 August 1947 to 30 August 1947 and that I last saw h.. alive on 30 August 1947

Immediate cause of death	DURATION
Cerebral accident	3 days.
Due to Fall from porch (18 ft)	3 days.
Due to	
Other conditions Delirium Tremens,	3 days

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? La Plata Chas Co.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Bowling's Hotel

Means of injury fell from porch (18 ft) Injured at work? no.

23. SIGNATURE A. O. Woodby, M.D.

M. D. or other

Address Box 214 La Plata, Md. Date signed 30 Aug. 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

06991

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 120

143c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: Welcome, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine years.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Charles.

City or town: Rural - Welcome.

(If outside city or town limits, write RURAL and give nearest town)

Street No. — Catholic Farm.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: SUSIE Anna Queen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro.	married.

6.(b) Name of husband ~~or wife~~: William Queen

16 August 1905 6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): August 21, 1908

8. AGE: Years: 38 | Months: 11 | Days: 7 | If less than one day: ...hrs. ...min.

9. Birthplace: Oaklee Farm, Welcome, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: Bernard Savoy.

13. Birthplace: Unknown.

MOTHER — 14. Maiden name: Dysie Proctor

15. Birthplace: Unknown.

16. Informant: Husband.

Address: Welcome, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-25-47 (month) (day) (year)

Cemetery or crematory: St Catherines

Location: Mt Church md

18. Funeral director: Hunter & Dyson

Address: Waldorf Md

19. aug 22 (Date rec'd by registrar) 18 47 W. L. Mosser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 August 1947 at 1:17 E.S.T. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 August 1947 to 21 August 1947 and that I last saw her alive on 20 August 1947

	DURATION
Immediate cause of death: Hemorrhage	20 min
Due to: pregnancy. 8 months	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: Injured at work?

23. SIGNATURE: A. B. Woodley, M.D. M. D. or other

Address: La Plata, Md. Date signed 21 Aug 47

06390

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH:
County: Charles
City or town: Hill Tok
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles.
City or town: Hill Tok.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles Ross

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife: Janie Ross
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Mch 1858

8. AGE:

Years	Months	Days	If less than one day
89	6	—	... hrs. ... min.

9. Birthplace: Charles Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER — 12. Name: Chas. Ross.
FATHER — 13. Birthplace: Chas Co. Md.
MOTHER — 14. Maiden name: Sadie Young
MOTHER — 15. Birthplace: Chas. Co. Md.
16. Informant: John Ross.
Address: Pisgah Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sep 3 1947 (month) (day) (year)
Cemetery or crematory: Little Zion
Location: Hill Tok. Md.
18. Funeral director: Stanley Penny
Address: Mason Springs Md
19. Sept. 3 1947 (Date rec'd by registrar) Mary E Bowie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1947, at 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947, to Aug 31 1947
and that I last saw him alive on Aug 29 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	
Arterial Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Bickell M.D.
M. D. or other
Address: Marbury Md Date signed Sep 3, 47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

06993

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: New Port
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: New Port
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Henry St Clair

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1859

8. AGE: Years 88 | Months 6 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace: St. Marys Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Charles Henry St Clair
13. Birthplace: St. Marys Co. Md.

MOTHER
14. Maiden name: Sarah Rowe
15. Birthplace: St. Marys Co. Md.

16. Informant: W. Raymond St Clair
Address: New Port

17. (Burial, cremation, or removal) Which? Burial Date thereof 8/8/47 (month) (day) (year)
Cemetery or crematory: St. Marys
Location: New Port, Md.

18. Funeral director: Hewitt & Ryon
Address: Waldorf, Md.

19. 8-8-47 (Date rec'd by registrar) 19 ... Julia L. Pace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 6 1947, at 330 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-8 1945 to 7-28 1947 and that I last saw him alive on 7-28 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	7-20-47
Due to: Gen. Art. Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: E. Edelen M.D.
M. D. or other
Address: La Plata Md. Date signed 8-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06394

932 — 105

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Charles

City or town: Marshall Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Marshall Hall Park.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 138 E. 57 S.E. Wash. D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: George Shanks.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 52 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mississippi (Town, county, and state)

10. Usual occupation: .....

11. Industry or business: .....

FATHER — 12. Name: Mississippi

13. Birthplace: "

MOTHER — 14. Maiden name: Mississippi

15. Birthplace: .....

16. Informant: John R. Purdy

Address: 1121 1/2 D St. S.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-23-47 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Washington DC

18. Funeral director: Hunt & Ryan

Address: Waldorf Md

19. August 21 19 47 M. L. Mowell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 19 47, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: 1 day

Due to: Chronic Myocarditis — 3 yrs.

Due to: Deceased was dancing at Marshall Hall Park & death is believed due

Other conditions: to CORONARY OCCLUSION

brought on by exertion. Informant

(Include pregnancy within 3 months of death) states he has had previous

Major findings of operations: heart attacks. Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frantz G. Susan M.D. Acting Coroner M. D. or other

Address: Indian Head Md. Date signed: 8/20/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

946

06992

Reg. Diat. No. 109

1. PLACE OF DEATH:
County: Charles
City or town: Issue Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Rt 6 Issue Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James Short

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	married

6.(b) Name of husband or wife: Sarah Short
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): unknown 1883

8. AGE:

Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Norfolk Va.
(Town, county, and state)
10. Usual occupation: Policeman Train
11. Industry or business:
FATHER 12. Name: Thomas Short
13. Birthplace: Norfolk Va
MOTHER 14. Maiden name: Virginia Conway
15. Birthplace: Norfolk Va.
16. Informant: Sarah Short
Address: Issue Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-13-47 (month) (day) (year)
Cemetery or crematory: Holy Ghost
Location: Pasadena Md.
18. Funeral director: Hunt & Glynn
Address: Waldorf
19. 8/13/47 (Date rec'd by registrar) William J. Hoe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-11-1947, at 7.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sudden death to 19
and that I last saw h— alive on 19

Immediate cause of death	DURATION
Angina Pectoris	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. L. Higdon M. D. or other
Address: Maryland Date signed 8-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

159 7510

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 106

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Charles
   City or town Boyds Road
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Mason Springs.
   Length of mother's stay in County 2 yrs
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Md
   County Charles
   City or town Mason Springs
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. —
   (If RURAL give LOCATION)

3. Name of child Baby Female
4. Date of birth 8/20 1947 Hour 11:30 A.M.
5. Sex Male | 6. Twin or triplet
7. No. of weeks pregnancy 24

FATHER OF CHILD

8. Full name Theodore P. Thompson
9. Color Col 10. Age at time of this birth 21 yrs.
11. Usual occupation Laborer

MOTHER OF CHILD

12. Full maiden name Helen C. Robinson
13. Color Col. 14. Age at time of this birth 21 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of None
19. Labor: (a) Complications of None
    (b) Induced?
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Prematurity
    (b) Maternal causes 0

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature Pomankey Md
    (Specify if M. D., midwife, or other)
    Address Mollie L Clark

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 8-20-47 (month) (day) (year)
    (c) Cemetery or crematory St. Charles, Glymont
24. (a) Funeral director None
    (b) Address

25. (a) 8/20/47 (Date rec'd by registrar) (b) Olay Price (Registrar)
26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

* See Instruction C on stub.

Child lived 5 minutes.